



BlueCare Plus (HMO D-SNP)SM

BlueCare Plus Choice (HMO D-SNP)SM

BlueCare Plus Select (HMO D-SNP)SM

2026 Info You May Need

> Hello!

This booklet has some important info and materials you may need this year. If you have questions about any of it, give us a call. We'll walk you through the details.

Table of Contents

How to fight fraud	1
Legal resources	2
Appointment of Representative form	5
HIPAA form	7
Your privacy	9
Nondiscrimination notice	13



Questions? Please call us.
1-800-332-5762, TTY 711



When it comes to caring for you, we're in this together. And that means working together to help protect you from fraud. Here are some ways to help keep your information safe:

- › Share your information only with people you know.
- › Remember you don't have to give your Member ID or Medicare number to anyone for free services (like at a community health fair).
- › If you order your prescription drugs online, be sure to use our mail-order delivery program. Don't order from online pharmacies outside our network.
- › Be careful what links you click in emails or pop-up ads online.
- › Write down suspicious phone numbers and report them.



1-888-343-4221

You can report fraud to us by calling our Fraud/Compliance Hotline.

➤ Legal resources

Do you have a complaint?

Do you have a complaint about the way you've been treated by us or one of your doctors or providers? If so, you can file a complaint. (This is also called filing a grievance.) You can't be dropped from your health plan for filing a complaint.

How to file a grievance

Just give us a call at **1-800-332-5762**, TTY **711**. Or you can complete our grievance form. You can find it online at **bluecareplus.bcbst.com/documents** under **Grievances**. Once you print it and fill it out, you can send it to us by mail or fax at:

› **Mail:**
BlueCare Plus Tennessee
Grievance
1 Cameron Hill Circle, Suite 43
Chattanooga, TN 37402-0043

› **Fax: 1-888-416-3026**

Do you think we've made a mistake?

If you disagree with a decision we made, you can file an appeal. An appeal is for when we've denied a claim or request for services. It asks us to look at our decision again and change it. We might still say no. But if we do, we'll walk you through your next steps.

How to file an appeal

You have 60 days from the date on the written notice we send you. If you send an appeal after 60 days, you have to show good cause for why it's late. We have an appeal form on our website you can use. It has all

the details we'll need from you. But you don't have to use that form. You can also write an appeal on plain paper and send it to us by mail or fax at:

› **Mail:**
BlueCare Plus Tennessee
Appeals
1 Cameron Hill Circle, Suite 42
Chattanooga, TN 37402-0042

› **Fax: 1-888-416-3026**

If you want someone else to file your appeal for you, you can appoint them as your representative. You just need to fill out the Appointment of Representative (AOR) form we've included on page 5. You and your representative will both need to sign and date it. Then you can send it to us with your appeal.

Remember that when you appoint a representative, they'll be able to:

- › **Get information about your claims**
- › **Tell us what you want us to know about your appeal**
- › **Make requests as if they were you**
- › **Give and get information about your appeal**

There are more details about appeals and grievances in your plan's Evidence of Coverage. You can find it online at **bluecareplus.bcbst.com/documents**. But if you have questions, we're here to help answer them. Just give us a call at **1-800-332-5762**, TTY **711**.

➤ **Make important health decisions ahead of time**

Many of us have an idea of what we would want done for us in case of an accident or illness. But it's a good idea to make sure your family or health care providers know, too. That's exactly what an advance care plan or advance directive does. It's a list of written decisions you get to make yourself ahead of time.

If you want to fill out an advance care plan or advance directive, call us. We can send you the paperwork and answer any questions you have. Or talk to your Primary Care Provider. They can help, too.



**Questions? Please call us.
1-800-332-5762, TTY 711**

Forms you may need:

If you have someone who represents you, these forms will make it easier for them to work with us. You'll need to fill out both forms.

1 Appointment of Representative (AOR) — pg. 5

This form tells us if you want someone to act on your behalf. They'll be able to see all your information and file a grievance or an appeal for you. You'll have to update this info each year.

2 HIPAA Authorization Form — pg. 7

This form lets us use or disclose protected health information as stated.



Mail completed form to:

Attn: BlueCross BlueShield of Tennessee
BlueCare Plus Correspondence
1 Cameron Hill Circle, Suite 0005
Chattanooga, TN 37402



Questions? Please call us.
1-800-332-5762, TTY 711

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)
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Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint the individual named in Section 2 to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date
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Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date
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INSTRUCTIONS AND REGULATION REQUIREMENTS

Instructions

Name of Party (required): This is the name of the person or entity which has standing to file a claim or appeal (the name of the person who has Medicare, or the name of the provider or supplier).

Medicare Number or National Provider Identifier (required): This must be completed when the person or entity appointing a representative has a Medicare number or National Provider Identifier. If not applicable, fill in, "not applicable".

All fields in Sections 1 and 2 are required unless noted as optional within the field. See the regulation at [42 CFR 405.910](#).

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, OMHA-118, "Petition to Obtain Approval of a Fee for Representing a Beneficiary" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. The form, OMHA-118, may be found at: <https://www.hhs.gov/sites/default/files/OMHA-118.pdf>

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227, TTY users call 1-877-486-2048), or your Medicare plan.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit <https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice>, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Authorization (Health Plan)

Purpose: This form is used to authorize us to use or disclose protected health information or for another person to disclose protected health information to us for the purpose stated.

SECTION A: Psychotherapy notes.

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

SECTION B: Individual authorizing use and/or disclosure.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number (optional): _____

SECTION C: The use and/or disclosure being authorized.

Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed:

Entities Authorized to Use or Disclose: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who you are authorizing to make use of and/or to disclose the protected health information described above:

Entities Authorized to Receive: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, to whom you are authorizing the disclosure and subsequent use of the protected health information described above:

Purpose of this Authorization:

☐ At request of individual

☐ For the following purposes:

AUTHORIZATION

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION D: Expiration and revocation.

Expiration: This authorization will expire (complete one):

☐ On ____ / ____ / ____

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office:

BlueCross BlueShield of Tennessee
Privacy Office
1 Cameron Hill Circle
Chattanooga, TN 37402

INDIVIDUAL'S SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Please return completed form to:

BlueCross BlueShield of Tennessee
Privacy Office
1 Cameron Hill Circle
Chattanooga, TN 37402

Notice of Privacy Practices (NOPP)

This notice describes how information we have about you may be used and shared, and how you can get access to this information. Please review it carefully.

LEGAL OBLIGATIONS

The law requires Volunteer State Health Plan, Inc. dba BlueCare Plus Tennessee and certain subsidiaries and affiliates of BlueCross BlueShield of Tennessee, Inc. ("we," "us," "our") to give this notice of privacy practices to all our members. This notice lets you know about our legal duties and your rights when it comes to your information and privacy.

The law requires us to keep private all of the information we have about you, including your name, address, other demographic information, claims information, financial information, (including Social Security number), diagnosis information, other health information, and other information that can identify you (your "information"). The law requires us to follow all the privacy practices in this notice from the date on the cover until we change or replace it.

We have the right to make changes to our privacy practices and this notice at any time, but we will send you a new notice any time we do. Any changes we make to this notice will apply to all information we keep, including information created or received before we made changes.

Please review this notice carefully and keep it on file for reference. You may ask us for a copy of this notice at any time. To get one, please contact us at:

CONNECT WITH US

Privacy Office

BlueCross BlueShield of Tennessee

1 Cameron Hill Circle, Chattanooga, TN 37402

Phone: 888-455-3824 | Fax: 423-535-1976

E-mail: privacy_office@bcbst.com

For additional information, including TTY/TDD users, please call the Privacy Office at **1-888-455-3824**. Para obtener ayuda en español, llame al **1-888-455-3824**.

You may reach out to us at this address or phone number to ask questions or make a complaint about this notice or how we've handled your privacy rights. You may also submit a written complaint to the U.S. Department of Health and Human Services (HHS). Just ask us for their address, and we will give it to you.

We support your right to protect the privacy of the information we have about you. We won't retaliate against you if you file a complaint with HHS or us.

ORGANIZATIONS THIS NOTICE COVERS

This notice applies to Volunteer State Health Plan, Inc. dba BlueCare Plus Tennessee. We may share your information with any of the following subsidiaries and affiliates as set forth below: Group Insurance Services, Inc., Golden Security Insurance Co., SecurityCare of Tennessee, Inc., Shared Health Mississippi and BlueCross BlueShield of Tennessee, Inc.

These entities support us in providing health insurance and related products and services. If we buy or create new affiliates or subsidiaries, they may also be required to follow the privacy practices outlined in this notice.

HOW WE MAY USE AND SHARE YOUR INFORMATION

We typically use your information for treatment, payment, or health care operations. Sometimes we are allowed, and sometimes we are required, to use or share your information in other ways. This is usually to contribute to the public good, such as public health and research.

Some states may have more stringent laws. When those laws apply to your information, we follow the more stringent law. Specifically, Tennessee law and other state and federal laws may require us to obtain your consent for uses and disclosures of behavioral health information, alcohol and other substance use disorder information, and genetic information.

Information about members and former members may be used and shared for treatment, payment, and health care operations.

We restrict access to information about you to those employees or contractors who need to know that information to run our business. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your information.

SOURCES OF INFORMATION WE COLLECT AND SHARE

We collect information about you from the following sources:

1. Information we receive from you: We collect health plan information directly from you. For example, we collect information like your name, address, and Social Security number when you apply for insurance or complete other forms, and we collect information like your name and contact information when you contact us for customer service requests.

2. Information about your transactions with us and our affiliates: We collect information about your relationship with us and with our affiliates. For example, we collect information about the claims we process like when you received health care, what services are covered and how much we've paid. We sometimes use affiliates and related entities to provide administrative services to process those claims, and they provide us with the same type of information about you.

3. Information about your transactions with non-affiliated third-parties: We collect information about your relationship with non-affiliated third-parties such as healthcare providers. For example, when your healthcare provider submits claims to us, it includes information about your encounter like diagnostic information, procedures you've had and the date of service

As permitted by law and this notice, we may use and share all of the information we have about you as described above.

WAYS WE MAY USE AND SHARE YOUR INFORMATION

We may use and share any of the information we have about you, including to nonaffiliated third-parties, in accordance with federal and state laws. The following are examples of how we may use or share your information — and the types of third-parties to whom we may share your information.

For your treatment: We may use or share your information with health care professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional care for you from other health care providers.

To make payments: We may use or share your information to pay claims for your care or to coordinate benefits covered under your health care coverage. For example, we may share your information with your dental provider to coordinate payment for dental services.

For health care operations: We may use or share your information to run our organization. For example, we may use or share it to measure quality, provide you with care management or wellness programs, and to conduct audit and other oversight activities.

To work with plan sponsors: We may share your information with your employer-sponsored group health plan (if applicable) for plan administration. For example, we may use or share your information to help verify your identity or to give you more information about your health insurance options. Please see your plan documents for all ways a plan sponsor may use this information.

For underwriting: We may use or share your information for underwriting, premium rating or other activities relating to the creation, renewal, or replacement of a health plan contract. We're not allowed to use or share genetic information for underwriting purposes.

Research: We may use or share your information in connection with lawful research purposes. For example, we may share your information as part of a limited data set given to a researcher for clinical research.

In the event of your death: If you die, we may share your information with a coroner, medical examiner, funeral director, or organ procurement organization.

To help with public health and safety issues: We can share information about you in certain situations, such as:

- › Preventing disease
- › Assisting public health authorities in controlling the spread of disease such as during pandemics
- › Helping with product recalls
- › Reporting negative reactions to medications
- › Reporting suspected abuse, neglect, or domestic violence
- › Preventing or reducing a serious threat to anyone's health or safety

As required by law: We may use or share your information as required by state or federal law.

To comply with a court or administrative order: Under certain circumstances, we may share your information in response to a court or administrative order, subpoena, discovery request or other lawful process.

To address workers' compensation, law enforcement and other government requests: We can use or share information about you:

- › For workers' compensation claims
- › For law enforcement purposes, or with a law enforcement official
- › With health oversight agencies for legal activities
- › To comply with requests from the military or other authorized federal officials

With your permission: Some uses and disclosures of information require your written authorization, including certain instances if you want us to share your information with anyone. You may cancel your authorization in writing at any time, but doing so won't affect any use or disclosure that happened while your authorization was valid.

For example, we would need your written authorization for:

- › Most uses and disclosures of psychotherapy notes
- › Uses and disclosures of your information for marketing
- › Sale of your information
- › Other uses and disclosures not described in this notice

We will let you know if any of these circumstances arise. We cannot use or share information except as described in this notice without your written authorization.

YOUR INDIVIDUAL RIGHTS

To access your records: You have the right to view and get copies of your information that we maintain, with some exceptions. You must make a written request, using a form available from the Privacy Office, to get access to your information.

If you ask for copies of your information, we may charge you a reasonable, cost-based fee for staff time and postage if you want us to mail the copies to you. If you ask for this information in another format, this charge will reflect the cost of giving you the information in that format. If you prefer, you may request a summary or explanation of your information, which may also result in a fee. For details about fees we may charge, please contact the Privacy Office.

To see who we've shared your information to: You have the right to receive a list of most disclosures we (or a business associate on our behalf) made of your information within the last six years, other than those made for the purpose of treatment, payment, or health care operations, and certain other disclosures. This list will include the date of the disclosure, what information was shared, the name of the person or entity it was shared to, the reason for the disclosure and some other information.

If you ask for this list of disclosures more than once in a 12-month period, we may charge you based on the cost of responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of these charges.

To ask for restrictions: You have the right to ask for restrictions on how we use or share your information. We're not required to agree to these requests except in limited circumstances. If we agree to a restriction, you and we will agree to the restriction in writing. Please contact the Privacy Office for more information.

To get notified of a breach: We will notify you after an unauthorized acquisition, access, use or disclosure of your unsecured health information that compromises the security or privacy of the information.

To ask for confidential communications: You have the right to ask us in writing to send your information to you at a different address or by a different method if you believe that sending information to you in the normal manner will put you in danger. We have to grant your request if it's reasonable. We will also need information from you, including how and where to communicate with you. Your request must not interfere with payment of your premiums.

If there's an immediate threat, you may make your request by calling the Member Service number on the back of your Member ID card or the Privacy Office. Please follow up your call with a written request as soon as possible.

To ask for changes to your personal information: You have the right to request in writing that we revise your information. Your request must be in writing and explain why the information should be revised. We may deny your request, for example, if we

received (but didn't create) the information you want to amend. If we deny your request, we will write to let you know why. If you disagree with our denial, you may send us a written statement that we will include with your information.

If we grant your request, we will make reasonable efforts to notify people you name about this change. Any future disclosures of that information will be revised.

To request another copy of this notice: You can ask for a paper copy of this notice at any time, even if you got this notice by email or from our website. Please contact the Privacy Office at the address on page 1.

To choose a personal representative: You may choose someone to exercise your rights on your behalf, such as a power of attorney. You may also have a legal guardian exercise your rights. We will work with you if you'd like to make this effective.

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries SecurityCare of Tennessee, Inc. and Volunteer State Health Plan, Inc. also doing business as BlueCare Tennessee, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex¹. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language assistance services to people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Member Service at the number on the back of your Member ID card or call **1-800-332-5762, TTY 711**. From **Oct. 1 to March 31**, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside of these hours and during holidays.

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance").

For help with preparing and submitting your Nondiscrimination Grievance, contact Member Service at the number on the back of your Member ID card or call **1-800-332-5762, TTY 711**. They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Grievance; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; 423-591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD), Monday through Friday, 8:00am to 6:00 pm, ET. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (phone), Nondiscrimination_CoordinatorGM@bcbst.com (email), or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bluecareplus.bcbst.com

BlueCare Plus Tennessee, an Independent Licensee of the Blue Cross Blue Shield Association

¹ Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-332-5762 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-332-5762 (TTY: 711) o hable con su proveedor.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-332-5762 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-332-5762 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

注意: 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 1-800-332-5762 (文本电话: 711) 或咨询您的服务提供者。

ध्यान आपो: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-332-5762 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-332-5762 (TTY : 711) ou parlez à votre fournisseur.

ማሳሰቢያ:- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጽ ለማቅረብ ተገቢ የሆኑ ተጨማሪ አገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-800-332-5762 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-332-5762 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-332-5762 (TTY: 711) или обратитесь к своему поставщику услуг.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-332-5762 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة.

توجه: اگر [وارد کردن زبان] صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 1-800-332-5762 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-332-5762 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル (誰もが利用できるよう配慮された) な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-332-5762 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-332-5762 (TTY: 711) ຫຼື ສົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-332-5762 (TTY: 711) o makipag-usap sa iyong provider.

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

[illegible]

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**Questions? Please call us.
1-800-332-5762, TTY 711**



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